GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ANTIBIOTICS, GI PA SUMMARY

Preferred	Non-Preferred
Metronidazole tablets generic Neomycin generic Vancomycin generic	Dificid (fidamoxicin) Paromomycin generic Xifaxan (rifaximin)

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Dificid

- Approvable for members 6 months of age or older for the treatment of *Clostridioides* (*Clostridium*) difficile-associated diarrhea (C. difficile) who have nonfulminant disease

AND

- For severe cases, member must have experienced inadequate response, allergy, contraindication, drug-drug interaction, intolerable side effect or resistance to vancomycin

OR

- For nonsevere cases, member must have experienced inadequate response, allergies, contraindications, drug-drug interactions, intolerable side effects or resistance to metronidazole and vancomycin.
- In addition for the oral suspension for members weighing 12.5 kg or more, the member must be unable to swallow solid oral dosage formulations (i.e., tablets).

Paromomycin

- Approvable for members with a diagnosis of intestinal amebiasis (*Dientamoeba fragilis*, *Entamoeba histolytica*) including asymptomatic intestinal colonization who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to metronidazole or tinidazole.
- Approvable for members 18 years of age or older a diagnosis of hepatic coma or hepatic encephalopathy when being used to suppress intestinal bacterial growth and the member has experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to neomycin.
- Approvable for members with a diagnosis of cryptosporidiosis (*Cryptosporidium parvum*) in human immunodeficiency virus (HIV)-infected patients when used in combination with antiretroviral therapy (ART), symptomatic treatment, rehydration and electrolyte replacement.

Xifaxan

- Approvable for members 12 years of age or older with a diagnosis of traveler's diarrhea caused by noninvasive strains of *Escherichia coli* who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least two of the following preferred products: ciprofloxacin, ofloxacin and azithromycin.

- ❖ Approvable for members 18 years of age or older with a diagnosis of hepatic encephalopathy who are taking lactulose or have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to lactulose.
- ❖ Approvable for a diagnosis of irritable bowel syndrome with diarrhea in members 18 years of age or older who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to loperamide or alosetron (Lotronex).

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA AND APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL list.